



February 22, 2002

ENGROSSED HOUSE BILL No. 1233

DIGEST OF HB 1233 (Updated February 20, 2002 12:16 PM - DI 104)

Citations Affected: IC 12-7; IC 12-15; IC 12-17.6.

Synopsis: Mental health drugs for Medicaid recipients. Prohibits the use of prior authorization for certain mental health drugs under Medicaid and the children's health insurance program (CHIP). Provides that this prohibition does not apply to a formulary or prior authorization program operated by a managed care organization under the Medicaid or CHIP programs. Establishes procedures to follow for requiring prior authorization for other drugs under the Medicaid and CHIP programs. Allows the office of Medicaid policy and planning to place limits on quantities dispensed or the frequency of refills for any covered drug for the purpose of preventing fraud, abuse, waste, overutilization, or inappropriate utilization or to implement disease management. Provides that the assessment on certain facilities for the developmentally disabled and mentally retarded may not exceed 10% of the facility's total annual revenue.

Effective: Upon passage.

**Crosby, Brown C, Scholer, Becker,
Budak**

(SENATE SPONSORS — GARD, BREAUX, LAWSON C)

January 10, 2002, read first time and referred to Committee on Public Health.

January 30, 2002, amended, reported — Do Pass.

February 4, 2002, read second time, ordered engrossed.

February 5, 2002, engrossed. Read third time, passed. Yeas 88, nays 1.

SENATE ACTION

February 11, 2002, read first time and referred to Committee on Health and Provider Services.

February 21, 2002, reported favorably — Do Pass.

EH 1233—LS 7006/DI 77+



C
o
p
y

February 22, 2002

Second Regular Session 112th General Assembly (2002)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type~~.

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~this style type~~ reconciles conflicts between statutes enacted by the 2001 General Assembly.

ENGROSSED HOUSE BILL No. 1233

A BILL FOR AN ACT to amend the Indiana Code concerning human services.

Be it enacted by the General Assembly of the State of Indiana:

1 SECTION 1. IC 12-7-2-51.8 IS ADDED TO THE INDIANA CODE
2 AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE
3 UPON PASSAGE]: **Sec. 51.8. "Cross-indicated drug", for purposes**
4 **of IC 12-15-35.5, has the meaning set forth in IC 12-15-35.5-2.**

5 SECTION 2. IC 12-7-2-178.5 IS AMENDED TO READ AS
6 FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 178.5. "Single
7 source drug" ~~for purposes of IC 12-15-35-35, has the meaning set forth~~
8 ~~in IC 12-15-35-35(a).~~ **means an outpatient drug that is produced or**
9 **distributed under an original new drug application approved by**
10 **the federal Food and Drug Administration, including a drug**
11 **product marketed by any cross-licensed producers or distributors**
12 **operating under the new drug application.**

13 SECTION 3. IC 12-15-35-35, AS AMENDED BY P.L.231-1999,
14 SECTION 6, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
15 UPON PASSAGE]: Sec. 35. (a) ~~As used in this section, "single source~~
16 ~~drug" means a covered outpatient drug that is produced or distributed~~
17 ~~under an original new drug application approved by the federal Food~~

EH 1233—LS 7006/DI 77+



C
o
p
y

1 and Drug Administration, including a drug product marketed by any
 2 cross-licensed producers or distributors operating under the new drug
 3 application.

4 (b) (a) Before the board develops a program to place a single source
 5 drug on prior approval, restrict the drug in its use, or establish a drug
 6 monitoring process or program to measure or restrict utilization of
 7 single source drugs other than in the SURS program, the board must
 8 meet the following conditions:

9 (1) Make a determination, after considering evidence and credible
 10 information provided to the board by the office and the public,
 11 that placing a single source drug on prior approval or restricting
 12 the drug's use will not:

13 (A) impede the quality of patient care in the Medicaid
 14 program; or

15 (B) increase costs in other parts of the Medicaid program,
 16 including hospital costs and physician costs.

17 (2) Meet to review a formulary or a restriction on a single source
 18 drug after the office provides at least thirty (30) days notification
 19 to the public that the board will review the formulary or
 20 restriction on a single source drug at a particular board meeting.

21 The notification shall contain the following information:

22 (A) A statement of the date, time, and place at which the board
 23 meeting will be convened.

24 (B) A general description of the subject matter of the board
 25 meeting.

26 (C) An explanation of how a copy of the formulary to be
 27 discussed at the meeting may be obtained.

28 The board shall meet to review the formulary or the restriction on
 29 a single source drug at least thirty (30) days but not more than
 30 sixty (60) days after the notification.

31 (3) Ensure that:

32 (A) there is access to at least two (2) alternative drugs within
 33 each therapeutic classification, if available, on the formulary;
 34 and

35 (B) a process is in place through which a Medicaid recipient
 36 has access to medically necessary drugs.

37 (4) Reconsider the drug's removal from its restricted status or
 38 from prior approval not later than six (6) months after the single
 39 source drug is placed on prior approval or restricted in its use.

40 (5) Ensure that the program provides either telephone or FAX
 41 approval or denial Monday through Friday, twenty-four (24) hours
 42 a day. The office must provide the approval or denial within

C
o
p
y



twenty-four (24) hours after receipt of a prior approval request.
The program must provide for the dispensing of at least a
seventy-two (72) hour supply of the drug in an emergency
situation or on weekends.

(6) Ensure that any prior approval program or restriction on the
use of a single source drug is not applied to prevent acceptable
medical use for appropriate off-label indications.

~~(e)~~ (b) The board shall advise the office on the implementation of
any program to restrict the use of brand name multisource drugs.

~~(d)~~ (c) The board shall consider:

(1) health economic data;

(2) cost data; and

(3) the use of formularies in the non-Medicaid markets;

in developing its recommendations to the office.

SECTION 4. IC 12-15-35.5 IS ADDED TO THE INDIANA CODE
AS A NEW CHAPTER TO READ AS FOLLOWS [EFFECTIVE
UPON PASSAGE]:

Chapter 35.5. Prescription Drugs

**Sec. 1. (a) Except as provided in subsection (b), this chapter
applies to:**

(1) the Medicaid program under this article; and

(2) the children's health insurance program under IC 12-17.6.

**(b) This chapter does not apply to a formulary or prior
authorization program operated by a managed care organization
under a program described in subsection (a).**

**Sec. 2. As used in this chapter, "cross-indicated drug" means a
drug that is used for a purpose generally held to be reasonable,
appropriate, and within the community standards of practice even
though the use is not included in the federal Food and Drug
Administration's approved labeled indications for the drug.**

**Sec. 3. (a) Except as provided in subsection (b), the office may
establish prior authorization requirements for drugs covered
under a program described in section 1(a) of this chapter.**

**(b) The office may not require prior authorization for the
following single source or brand name multisource drugs:**

**(1) A drug that is classified as an antianxiety, antidepressant,
or antipsychotic central nervous system drug in the most
recent publication of Drug Facts and Comparisons (published
by the Facts and Comparisons Division of J.B. Lippincott
Company).**

(2) A drug that, according to:

(A) the American Psychiatric Press Textbook of



Psychopharmacy;
 (B) Current Clinical Strategies for Psychiatry;
 (C) Drug Facts and Comparisons; or
 (D) a publication with a focus and content similar to the
 publications described in clauses (A) through (C);
 is a cross-indicated drug for a central nervous system drug
 classification described in subdivision (1).

(3) A drug that is:

(A) classified in a central nervous system drug category or
 classification (according to Drug Facts and Comparisons)
 that is created after the effective date of this chapter; and
 (B) prescribed for the treatment of a mental illness (as
 defined in the most recent publication of the American
 Psychiatric Association's Diagnostic and Statistical Manual
 of Mental Disorders).

(c) Except as provided under section 7 of this chapter, a
 recipient enrolled in a program described in section 1(a) of this
 chapter shall have unrestricted access to a drug described in
 subsection (b).

Sec. 4. Prior authorization requirements developed under this
 chapter must:

(1) comply with all applicable state and federal laws,
 including the provisions of 405 IAC 5-3 and 42 U.S.C.
 1396r-8(d)(5); and

(2) provide that the prior authorization number assigned to
 an approved request be included on the prescription or drug
 order:

(A) issued by the prescribing physician; or

(B) if the prescription is transmitted orally, relayed to the
 dispensing pharmacist by the prescribing physician.

Sec. 5. Before requiring prior authorization for a single source
 drug, the office shall seek the advice of the drug utilization review
 board, established by IC 12-15-35-19, at a public meeting of the
 board.

Sec. 6. (a) The office shall publish the decision to require prior
 authorization for a single source drug in a provider bulletin.

(b) IC 12-15-13-6 applies to a provider bulletin described in
 subsection (a).

Sec. 7. (a) Subject to subsection (b), the office may place limits
 on quantities dispensed or the frequency of refills for any covered
 drug for the purpose of:

(1) preventing fraud, abuse, waste, overutilization, or



C
O
P
Y

1 inappropriate utilization; or

2 (2) implementing a disease management program.

3 (b) Before implementing a limit described in subsection (a), the
4 office shall:

5 (1) consider quality of care and the best interests of Medicaid
6 recipients;

7 (2) seek the advice of the drug utilization review board,
8 established by IC 12-15-35-19, at a public meeting of the
9 board; and

10 (3) publish a provider bulletin that complies with the
11 requirements of IC 12-15-13-6.

12 SECTION 5. IC 12-17.6-4-2.5 IS ADDED TO THE INDIANA
13 CODE AS A NEW SECTION TO READ AS FOLLOWS
14 [EFFECTIVE UPON PASSAGE]: **Sec. 2.5. Prescription drugs**
15 **provided under the program are subject to the requirements of**
16 **IC 12-15-35.5.**

17 SECTION 6. IC 12-15-32-11, AS AMENDED BY P.L.291-2001,
18 SECTION 216, IS AMENDED TO READ AS FOLLOWS
19 [EFFECTIVE UPON PASSAGE]: Sec. 11. (a) The office may assess
20 community residential facilities for the developmentally disabled (as
21 defined in IC 12-7-2-61) and intermediate care facilities for the
22 mentally retarded (**ICF/MR**) (as defined in IC 16-29-4-2) that are not
23 operated by the state in an amount not to exceed ten percent (10%) of
24 the ~~total annual gross residential services~~ revenue of the facility for the
25 facility's preceding fiscal year.

26 (b) The assessments shall be paid to the office of Medicaid policy
27 and planning in equal monthly amounts on or before the tenth day of
28 each calendar month. The office may withhold Medicaid payments to
29 a provider described in subsection (a) that fails to pay an assessment
30 within thirty (30) days after the due date. The amount withheld may not
31 exceed the amount of the assessments due.

32 (c) Revenue from the assessments shall be credited to a special
33 account within the state general fund to be called the Medicaid
34 assessment account. Money in the account may be used only for
35 services for which federal financial participation under Medicaid is
36 available to match state funds. An amount equivalent to the federal
37 financial participation estimated to be received for services financed
38 from assessments under subsection (a) shall be used to finance
39 Medicaid services provided by facilities described in subsection (a).

40 (d) If federal financial participation to match the assessments in
41 subsection (a) becomes unavailable under federal law, the authority to
42 impose the assessments terminates on the date that the federal

C
o
p
y



1 statutory, regulatory, or interpretive change takes effect.
2 SECTION 7. **An emergency is declared for this act.**

C
o
p
y



COMMITTEE REPORT

Mr. Speaker: Your Committee on Public Health, to which was referred House Bill 1233, has had the same under consideration and begs leave to report the same back to the House with the recommendation that said bill be amended as follows:

Delete everything after the enacting clause and insert the following:

(SEE TEXT OF BILL)

and when so amended that said bill do pass.

(Reference is to HB 1233 as introduced.)

BROWN C, Chair

Committee Vote: yeas 13, nays 0.

C
o
p
y



COMMITTEE REPORT

Mr. President: The Senate Committee on Health and Provider Services, to which was referred House Bill No. 1233, has had the same under consideration and begs leave to report the same back to the Senate with the recommendation that said bill DO PASS.

(Reference is made to House Bill 1233 as printed January 31, 2002.)

MILLER, Chairperson

Committee Vote: Yeas 9, Nays 0.

C
o
p
y

EH 1233—LS 7006/DI 77+

